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THE

MEDICAL AND SURGICAL REPORTER.

No. 993.]

PHILADELPHIA, MARCH 11, 1876.

[VOL. XXXIV.—No. 11.

ORIGINAL DEPARTMENT.

LECTURE.

THE IMPORT OF AN ULCER, AND ITS TREATMENT.

BY GEORGE L. BEARDSLEY, A. M., M. D.

(Late Surgeon in Charge of Bureau of Surgical Relief, Bellevue Hospital, New York.)

The science of physiology refers us to a cell as the ultimate resolvent of animal tissue. The integrity of every factor in the economy, it argues, rests with the undisturbed evolution and renewal of this element. It affirms of health that it is a motion from one set of cells, whose office has been exercised, to another series whose prerogative of necessity to the being of the individual in turn becomes a question of dispute after its contributions have been surrendered. It recognizes, then, only an equilibrium between the repair and decay of tissue, pronounces every deviation an infraction on the original design, and discovers a constant stimulus in this exchange of cells to the several processes. Just here is the limit of its range. Pathology deals with this stimulus when in excess; when it behaves as an irritant; and it is this exalted or strained vitality on which the logic of inflammation, as I conceive of it, hinges. Let me christen it *molecular excitement*. To a limited extent, it foreshadows no destruction of any moment. On it we rely for plastic fibrin. When, however, these cells are more rapidly absorbed than reproduced, the inflammation is useless, the energy of the tissue is exhausted, the continuity of the surface is compromised, and an elimination of effete corpuscles started.

An ulcer, then, is a catarrhal disintegration of tissue.

Laws.—Ulcers elect the grounds for their culture. Their affinity is noticed for parts whose vascularity is lowered or power of repairing feeble. Cicatricial surfaces are quite vulnerable to them, and the same is true of serous and synovial membranes. But it is on the inferior extremities that ulcers thrive. On the crest of the tibia and on the malleoli the crop is particularly luxuriant. In these localities an atrophy of the tissue is favored by an occasional stasis of the blood, which contradicts its oxygenation. With such a predisposing cause, excitants, as friction or contusions, need not labor long to be successful.

The second observation is that ulcers are the local evidences of dyscrasias. The syphilitic cachexia prophesies them; they are pathological inferences of the scorbutic disposition. Tissues tainted by struma, mercury or lead, or charged with tubercle, furnish them a fertile soil. A hearty invitation is extended to ulcers by constitutions that are podagra. Whenever the constituents of the blood are corrupt, whether by inheritance or accidental infection; whenever the system reveals a proclivity to an imperfect coherence of its cells, a solution of structure is the law.

Clinical History.—The work of destruction invites attention first by a rupture of the skin. The subjacent structures then become red, with vessels distended, and covered with a viscid non-infectious deposit. Granulations, pale or livid, and scattered, stud the ground. Here end the first stage. The tissue around sooner or later breaks down, and without much effort

the entire patch resolves itself into a chasm with indurated or thin edges, and bathed in a fluid, half serous and half muco-purulent. The system at large does not generally sympathize with the local disturbance until the waste has progressed considerably. The hectic then seen is due, undoubtedly, to pyæmic impressions. A chill very commonly introduces this stage, and is soon succeeded by prostration. This line of symptoms does not, of course, apply to the "walking-cases;" with these, the annoyance is the burden of lament. They regard their affliction as an outrage on their cleanliness, a blight on the purity of their covering. Cases of ulceration that turn phagedenic seriously threaten life. Such are ever a bane to hospitals and on shipboard, rivaling in their deal of death puerperal phlebitis. Waiving now an examination further of ulcers as a class, I pass to their nosological arrangement. This it is not easy to fix, as the species has so many peculiarities. From time quite distant, authors have preferred unnecessary distinctions and divisions, at first classifying them according to causes, disposition to heal, duration; again, grouping them by locality, tendency to spread, associate constitutional disorders. The advantage of a common nomenclature seems not to have been appreciated. The student, as he wanders from treatise to treatise, finds a list of terms that by its incongruity perplexes and tempts him to collate all chronic suppurative surfaces under one head, as "sores." To avoid any empirical disposition of the trouble, and for convenience, I propose two orders: (a) Syphilitic; (b) Non-syphilitic. The variety non-syphilitic embraces four lines: the Ulcer Inflamed; the Ulcer Indolent; the Ulcer Varicose; the Ulcer Sinuous.

Ulcer Inflamed.—The propriety of specially designating any type as *inflamed* is open to criticism, as all ulcers, according to the views advanced, presuppose congestion. The phenomena of this class are, however, so positive as to merit an isolation from its neighbors. The decay is remarkably rapid and extensive, accompanied by a throbbing, burning sensation, and constitutional agitation simulating typhoid. The clinical features suggest a phlegmonous erysipelas. The granulations bleed easily, look huddled, and are immersed in an acrimonious and ichorous discharge. The excavation is quite deep, and the border shelves. The favorite site for them is the middle third of the tibia,

the nates, and cervical fasciæ. A case came under my treatment where the plalysma myoides was laid bare and dissected by such an ulceration.

Ulcer Indolent.—This is almost a counterpart of the preceding. Its significance lies only in the absence of granulations. A few are occasionally discernible, but they are mere apologies; their growth is inert, so far as repair is concerned. The margin is undermined, or notched and callous; the color ashy; the emissions watery; not offensive unless detained, and profuse. In my experience this variety has been associated with eczema. A tabulated report shows 40 per cent. with eczema rubra. In healing they are the most intractable, excepting, perhaps, the varicose, for the reason that the neighboring ground is so vitiated as to forbid reform. Fortunately, these have little ambition to enlarge their dominions. One on my books was cured after having remained stationary for five years.

Ulcer Varicose.—This is to be ranked among the sequelæ of the structural decay of veins. What the logic of this change is, whether local anæmia or passive congestion, is under arbitration. Probably only a mechanical member was in the original equation. Causes like pressure, attitude, ligature, must have figured at first. As soon as the varix is formed, its conversion into an ulcer is quite easy and rapid. The contents of these tumors seem noxious enough not only to induce a softening and rupture of their tunics, but to provoke the fasciæ to a similar rebellion. The tissues thus impoverished by a steady drain of blood, and charged with serous accumulations, allow a general liquefaction of the several layers to be quietly inaugurated. The ulcer has blossomed. Its outline is oval; edges ragged; its basin not as deep as with other kinds; the patch generally filmed with erums of derma, clots, and shreds of dead fibrin. These ulcers start where the veins bulge the most, and insidiously follow the countless doublings and plaits of the dilated vessels. Though not confined to the lower extremities, it is there that these curiosities are the most confirmed.

Ulcer Sinuous.—It is axiomatic in surgery that pus, unless liberated, will tunnel tissue until it enjoys an exit. The channel thus scooped out is somewhat clogged by clusters of ragged, impoverished granulations, which add their quota to the general flow of matter. This

species of ulceration dissembles a good deal in starting, but is in time attended by an irritation that lends much to the discomfort of the patient. It is virtually an open abscess. Its birth is to be traced to some suppurating cavity that has been imperfectly relieved of its contents; to sequestra that have not been extracted; to foreign substances that have lodged or become impacted in a fold of membrane; or a wound that did not heal from the bottom. These causes are ample to excite an inflammation, and the products very properly force an escape by cloacæ. Where the cellular substance predominates, as in the vicinity of the perineum, urethra, rectum, fistulæ prosper. A patient recently displayed no less than a dozen of sinuses in the right ischio-rectal fasciæ. After amputation in contiguity, if the ends of the bones have been denuded of periosteum, pus is frequently generated, and burrows the flaps at various points. Fistulæ may thus riddle a cicatrix until they involve it in a universal slough.

Ulcer Syphilitic.—By this term it is my design to classify the *remote* evidences of the infection. Chancres and chancroids are excluded from consideration, though they are often as faithful specimens of the virulence of the poison as are the later ravages, for the reason that they are not *bona-fide* representatives of the syphilitic impression, or, as Hunter has it, only "local complaints." It is, then, the distant and destructive changes in the system at large that our review concerns. The leading feature of this ulceration is its rapidity of progress. However latent the virus may remain, it atones for all tardiness by the ultimate assertion of its power to extract the life from tissue. Its violence of demonstration is not constant. It varies as the part affected, the treatment of the primary sores, the amount of constitutional pluck, the quick response of the system to medication. When the disease touches only the fibrous or osseous timber, the ulceration completes its work more after a law. A principle or plan is blended with its unravelings. On mucous surfaces it acts recklessly, seeming to exhaust itself at the onset in a speedy sundering of the structure.

Again: no ulcer is consistently syphilitic, unless it is preceded by some lesion of bone, or a degraded vitality of the skin. The eruptions peculiar to this zymosis need not here be catalogued. Suffice to say that they are identified with deposits that, by successive stages of solu-

tion, form ulcers. Long before the cuticle breaks we notice a positive discoloration, a roseola, but, unlike its non-specific analogues, dark brown. The shade is never uniform; speckled; here and there a copper-colored patch, the intervening spaces looking natural. In place of the roseola, some papular exanthem may initiate the disturbance; but, whatever the kind of syphilodermata, the tendency is to a formation of vesicles. This character is early lost in the scaly, so that the last stage of the eruption is the exfoliation of ill-developed cuticle. A low form of suppuration now succeeds, and the ulcer bursts into its full maturity, as a hole in the cellular tissue, with gnawed edges, and packed with purulent shreds of fibre and coagula, all swimming in a fluid notoriously putrid. When the walls are washed rid of the adhesive sloughs, a very vascular state is found to exist, and the manufacture of abortive granules demonstrated. A cause is thus worked up for the steady waste of tissue in the neighborhood. These sores also show a fondness for congregating, and the acridity of the discharge doubtless favors such a coalescence. The slough into which the field around early precipitates is seldom arrested in its march. Eventually periostitis is aroused, the bone becomes bored with cloacæ, and sequestra mix with the discharges. The order is often reversed, and the disease signals its inroad by a blow at bone first. Nodes degenerate with speed, and their liquefaction soon involves the overlying strata in a common death. The probe finds the bone a mere shell, a mortar-like mass. Syphilitic ulcers usually appear on the tibia near the crest. Nodes seldom submit to much irritation, and discover here abundant excuses for suppuration. The next favorite point is the olecranon. In this locality these sores seldom slough, and exhibit granulations which grow vigorous with a little encouragement. The phalanges of the hand and tarsus, the flexor tendons, fall a prey to this inflammation willingly. Twenty-one in these situations are on my records. The *os frontis* stands the fourth in susceptibility. The corona veneris in a case of mine was three inches in diameter. A fatal meningitis was excited by the pus penetrating the tables.

A neuralgia and a peculiar fatigue weary the patient for months before the nodes burst. Loss of sleep is a uniform complaint. As the exfoliation continues, the patient is annoyed by

a sense of "giving way" in the member, and values some form of support. This distress, with the inconvenience of the discharge, makes the mortal a pest to himself, and in his fancy miserable to others. Passing to a study of these ulcers on mucous surfaces, we find no new process. All have cutaneous patterns, and are striking only in their phagedenic disposition. Under no form of ulceration does tissue suffer from such havoc. The sores start as aphæ, or submucous tuberculæ, and in their conquests repeat the history of dermal syphilis. The demolition, however, is more rapidly consummated, as mucous tissue is never averse to inflammation, and with a fearful reduction of strength. A throat thus affected pictures a cavern crossed by bridges of ashy lymph, its velum perforated, the arch of the palate gone, and its bones detached. Case forty-one on my record tells of a "roof broken down four months after the vesicles were seen." Nasopharyngeal fistulae were traced in this, as in many other specimens. Deglutition becomes at the best painful, and changes of voice from huskiness to aphonia point to an invasion of the larynx. Permanent impairment of the function of the larynx is almost always its fate, and death by suffocation is to be apprehended from an extension of the disease.

Surgery of the rectum and vagina embraces ample evidences of this type of ulceration. Much of the stricture occasionally felt just above the anus is an organized band of deposits of syphilitic lymph, while not a few of the nutrition-changes of the uterus may be justly explained as legacies of this dyscrasia.

[To be Continued.]

COMMUNICATIONS.

ON THE TREATMENT OF DIPHTHERIA.

BY FORD S. DODDS, M. D.

Read before the Southern Illinois Medical Association, at Cairo, January 20th, 1876. Forwarded to the MEDICAL AND SURGICAL REPORTER by the Committee on Publication.

Among the diseases of recent origin that we as a profession have to contend with, none, probably, stares at us more ghastly than diphtheria. It is a disease we are liable to meet at any time, and among all classes, ages and sexes.

I hope to offer something on the treatment of this disease, which, if not new to all, may be made practically useful.

To afford some basis for curative measures,

we will first make a few observations on the pathology of the disease. The special pathology of diphtheria, with its anatomical lesions, is generally agreed upon; the fauces, and parts contiguous, being the region where the symptoms are localized, or where the derangement of the economy finds an explosive outlet. But when and from what causes the disease originates, by what process it is generated, how the poison is introduced into the system from without, the changes it produces in the blood, in the organs of respiration and nutrition, and why it develops itself in the fauces, are all questions open to investigation.

It was formerly supposed that all pathological changes took place in the solid parts of the organism, thereby affecting the fluids. Another class of teachers supposed that all the changes of disease originated in the fluids, which finally involved the solids. Another class of observers contended that all morbid impressions are received through the medium of the nerves.

Recent histological research has shown that all animals, as well as plants, are developed from cells, and that, besides the solids, the blood, and the nerves, there are many other things in the animal economy. In a certain sense, these cells possess an individual character or life, as much so as other organs possess an individual vitality.

Diphtheria is primarily a disease of the fluids of the system, but more particularly of the corpuscles of the blood. When the blood becomes infected with matter or material which causes diphtheria, its corpuscles become diseased, and tend to death and putrefaction.

With the exception of the poison generated within its own economy from some altered relations of the chemical and vital forces, almost all fomites of infectious diseases enter the system through the respiration and the lungs, or through the skin; and hence, when miasms and noxious gases enter the circulation so as to come in contact with and injure the corpuscles, and depress their vitality, then the symptoms of fever present themselves. If the conservative forces of the organism are overwhelmed and fail to expel the enemy, as the disorder spreads from one corpuscle to another, and more are involved, more intense will become the symptoms; and, by reaction upon the tissues, congestion, erosion, and decomposition of the structures are induced, and a derangement which was simply functional is now rendered organic.

The primitive diseased part, then, is the blood, which may have been changed from its normal condition by animal, mineral, aerial or vegetable poisons, received through the skin, lungs or stomach.

The inflammation of the fauces is the local expression of another disease, and in point of treatment it should not be regarded as a distinct local inflammation.

In treating diphtheria we should keep prominently before us the fact that the most important part of the treatment is to combat the blood-poison.

While local applications to the throat are quite essential, they are only secondary in importance to constitutional treatment. We never will succeed in curing diphtheria until we possess a remedy which will destroy or restrain the disease, or the virulent poison which causes it.

Those of you who were in the army will recollect that among the medical supplies furnished by the Government was a preparation called Bibron's antidote, manufactured by Squibb, of New York. The object of this preparation was to neutralize the blood-poison caused by the bite of a snake, tarantula, and other reptiles or insects. We had frequent occasions to use this remedy while camping through Mississippi, Alabama and Georgia. When given in conjunction with large doses of whisky or brandy, it always proved successful, so far as my observations went.

From this fact the idea suggested itself to my mind that if Bibron's antidote and whisky would neutralize the blood-poison from a snake bite, it might have the same effect upon the poison which creates diphtheria. The chemical nature of the two poisons may be different, one can be seen and analyzed, the other cannot. The constitutional symptoms differ in violence. In one case a large amount of poison enters the circulation *suddenly*; consequently the red corpuscles of the blood are broken down *rapidly*, and destruction and death of the organs follow *speedily*. The chemical changes which take place in the blood may be the same, but by a slower process in one than in the other.

Bibron's antidote is composed of—

R. Bromine,	fl. 3ijss
Iod. potass.,	gr. ij
Bichlor. mercury,	gr. j
Alcohol, diluted,	fl. 3xx. M.

Dose—One teaspoonful, well diluted.

I commenced using this formula as it stands, but soon after substituted the chlorate of potassa for the iodide. I generally repeat the dose at intervals of three to six hours, according to the severity of the case, alternate with large doses of whisky or brandy, given in the form of milk-punch or egg-nog, for the reason that they are more palatable in this way. Besides, milk and eggs, if not good curative remedies of themselves, are good prophylactics in all infectious diseases; especially milk, in large quantities. The alcoholic preparation should not be given prematurely; wait until the inflammatory and septic influence of the disease has been somewhat lowered by the ordinary antiphlogistics, and then push the remedy to the verge of intoxication.

It is astonishing what large quantities of alcoholic stimulants may be taken, even by children, in severe forms of diphtheria. An adult patient suffering from the poisonous effects of the bite of a serpent, will bear a pint of strong whisky in the course of an hour; while a child four years old, suffering from diphtheria, will bear three to four ounces in the course of a day.

So many remedies have been suggested for treating diphtheria locally, that they bewilder us. The application of ice, escharotics, and cauterization of the mucous membrane, I think are generally discarded by the profession. Sufficient reasons could be given why they should be, but it would prolong this article.

Glycerine, on account of its penetrating, softening and soothing influence, should enter into all the combinations we use for internal application to the throat. I know of nothing better for this purpose than a preparation like this:—

R. Sol. persulph. iron,	3ij
Potassa chloras,	3ij
Glycerine,	
Aqua,	aa 3j. M.

Add to this a sufficient quantity of carbolic or salicylic acid. The objectionable property of this new rival antiseptic is its insolubility in cold water. As the addition of borax and hot water will dissolve it readily, it should be kept prepared for use. This same preparation, diluted, will answer for a gargle. Let us accept the doctrine of microoocci insinuating themselves through the abraded or unabraded membrane. I can think of nothing better in the *materia medica* to torture these fungi with

than carbolic acid, combined in a formula similar to the one given above. The glycerine will penetrate as far, probably, as the parasites, carrying the carbolic acid with it. The preparation, however, should not be of sufficient strength to destroy the membrane. Yet high authority has recommended the destruction of the diseased tissue, and establishing a healthy suppuration underneath. If we should attempt to do this, half our patients would be dead before this could be accomplished. The throat should be cleansed soon after making the application, either by gargles or mopping it out with a soft sponge. Where the patient is unable to gargle, in order to get a more local effect on the diseased membrane, I give, every three hours, tinct. ferri chlor. with pot. chloras, dissolved in glycerine and water. Where malarious influence is suspected, I add quinine, either to this preparation or to the whisky.

In addition to the above, it is highly necessary to ventilate the sick-chamber, to keep a uniform high temperature and moist atmosphere in the room, and a thorough use of disinfectants. The temperature of the room should not vary from 76°. Moisture can be maintained by vessels filled with hot water. They can be kept steaming by means of hot bricks placed in them. Use carbolic acid freely as a disinfectant, placed in a large open vessel filled with water, and changed every three or four hours.

The ultimate and direct cause of death from diphtheria is a deposit of fibrin on the larynx and trachea, the result of blood-poison, which produces a state of the membrane similar to pseudo-membranous croup. Hence we have what is called diphtheritic croup. In this stage of the disease, inhalations of warm vapor, tinctured with iodine or bromine, are called for, and, if necessary, tracheotomy as a dernier resort.

Some eight or nine years ago diphtheria prevailed as an epidemic in the locality in which I live. It invaded my own family. It was during the prevalence of this epidemic that I adopted the plan of treatment already mentioned. I never read of the suggestion, nor conversed with any physician on the subject. The treatment being rather novel, I, of course, watched its effects closely, and found them so uniform that I could not abandon the remedy, and think it justly entitled to further investigation. I do not offer it as a specific, not being enthusiastic on that subject, and having as little

confidence in medicine, generally as any practitioner, probably, on the floor. I have quietly persisted in the treatment indicated with every case of diphtheria I have been called to treat within the past seven or eight years, and can say this as to the result, that not a single one is now under the sod, when I saw the patient in the early stage of the disease, and had exclusive control of the case. They might have recovered from the other remedies used, to the exclusion of Bibron's antidote, and plenty of whisky. My own convictions are different.

TUMOR OF THE LEFT ANTERIOR CENTRAL CONVOLUTION OF THE CEREBRUM.

TRANSLATED BY JOHN B. ROBERTS, M. D.,
From Archives Générales de Médecine, Jan., 1874.

A German laborer, aged fifty-six, presented, in June, 1875, the following symptoms: He was completely aphasic, answering all questions by "Ja, ja," or by an unintelligible murmur, and had almost entirely lost his mind. The right arm was totally paralyzed, and passive motion was painful; palsy of the corresponding leg, also, was pronounced, but not absolute. When supported under the arms, the patient dragged his right leg, and the foot scraped the floor; he could not stand erect for an instant. There was palsy of the right side of the face, but it was not marked, and only affected the naso-labial nerves. The pupils were alike moderately dilated, and reacted readily to light. In addition to the hemiplegia, there was right-sided anesthesia; and the reflex movements of the right foot were much less marked than those on the left side. Percussion of the right (?) frontal and temporal region was exceedingly painful. An ophthalmoscopic examination was made, with negative results. The urine contained neither albumen nor sugar. Pulse was 90, and the rectal temperature 38° C. (100.4° F.). There was observed at times a deviation of the head and eyes to the left, but when the patient was pushed to that side he carried his head and eyes equally to the right. The frontal and temporal regions on the left side were tender, even to the pressure of the finger.

The following history was obtained from his wife: The sickness dated from Christmas, 1871, when he was attacked with an epileptiform seizure, lasting about ten minutes.

During the paroxysm he made flexing motions of his right arm; and when he got up the next day, it was noticed that he dragged his leg slightly. Toward the end of January, 1875, he was seized with partial convulsions of the right side, without loss of consciousness. These convulsive attacks, at first infrequent, became more numerous, and finally occurred twenty or thirty times during the day. About April they ceased, but there remained right-sided hemiplegia, characterized by absolute paralysis of the arm, and dragging of the leg when walking. In May complete palsy of the right half of the face occurred, and then his mind began to be impaired. He never complained of headache.

Five days after admission the patient became drowsy, and the face greatly congested. The deviation of the head and eyes to the left was very marked, but passive motion of the head was readily made. There was nystagmus. Temperature, 38° C. (100.4° F.). Pulse small, and 80 per minute. In this condition the patient died.

Autopsy.—The dura mater was equally adherent on both sides. The cerebral convolutions were firm, but flattened, and closely pressed together, so that the furrows were completely effaced. There was no difference in the tension of the two hemispheres. On the left side a tumor, about the size of a small apple, was seen in the parietal region, through the pia mater, on a level with the surrounding convolutions. Laterally, and on a level with the convexity of the brain, the tumor was distinctly limited, but not so toward the median line. The pia mater was easily detached from the tumor, except at the longitudinal fissure.

The tumor extended backward to the central furrow, and in front was bounded by a vertical line which would meet the upper extremity of the fissura praecentralis. The inferior boundary was made by a horizontal line situated in the anterior central convolution, and distant about one and three quarter inches from the longitudinal fissure. The longest antero-posterior diameter was about two inches.

The tumor, then, was situated in the left anterior central convolution; occupying the upper third of this convolution on a level with the convex surface of the cerebrum, and almost all the middle portion of the convolution, on a level with the paracentral lobule described by Betz. The convolutions in the vicinity of the tumor were much flattened and widened. On section,

the tumor, which was a glioma, resembled an apple imbedded in the medullary substance; the surrounding tissues were softened, and almost fluctuating. No other lesion was found in the brain, and there was nothing abnormal in the other organs.

This case is of some interest, on account of the experiments of Hitzig and Ferrier, and because the disease did not involve that region which, according to the observations of Turck, Charcot and Vulpian, is implicated when hemianesthesia results.

MEDICAL SOCIETIES.

NEW YORK PATHOLOGICAL SOCIETY.

Stated meeting, February 9th, 1876, Dr. Charles K. Briddon, President, in the chair.

Hyperæmia of Epiglottis, Larynx and Trachea—Edema of Lungs—Pyelitis.

Dr. Jacobi presented the larynx, trachea, lungs and kidneys taken from a patient who died in Bellevue Hospital. The history was as follows:—

Jessie Turry, aged twenty-four, was admitted on February 4th. Her habits had been intemperate. Last November she had had a miscarriage. All further history was unsatisfactory. For ten days previous to her admission she had suffered from dyspnoea. This symptom was marked on admission, and was accompanied by aphony. The respiration was between 26 and 30, and the temperature in the vagina 99 $\frac{1}{2}$. Laryngotomy was performed on February 5th, by Dr. Welch, the house-physician, after which the patient rallied for a short time, but died on the following day, of pulmonary edema. The urine had been examined only after death, and was loaded with albumen, its specific gravity being 1.012. On February 5th, when the patient was seen by Dr. Jacobi, she manifested symptoms of laryngeal obstruction. On examining the chest, localized dullness was found over portions of the left lung, and it was thought to have been, probably, broncho-pneumonic. The tongue and pharynx were dry, hard, and furrowed; the surface of the former was red and scaly, and its papillæ elevated. The pharyngeal space was somewhat contracted, and the epiglottis hard and dry, and did not move readily. Dr. Jacobi had diagnosed laryngitis, tracheitis and broncho-pneumonia.

Autopsy.—The epiglottis, larynx, and trachea were hyperæmic. The larynx and lungs were edematous, but this condition was only a consequence of her dying condition, as it did not exist twenty-four hours prior to death. The lungs were also the seat of condensation at different points; there were no changes, however, of an anterior date to the present illness. The spleen was enlarged and lobulated (like a fetal

one), and measured six inches in length. The main point of interest about this case was the condition of the kidneys; they were both the seat of old diffuse nephritis, with condensation of tissue and abscesses. The condition of the kidneys had been the cause of the oedema of the lungs, but had not been diagnosed during life.

Dr. Seguin said that he had observed dryness of the mucous membrane of the fauces in a few cases of uremia.

Dr. Jacobi said that in this case epithelial scales were visible upon the surface of the tongue, and in his opinion it was a mild form of ichthyosis.

Softening of Spinal Cord—Cyst in Kidney—Carcinoma of Stomach, Presenting no Characteristic Symptoms during Life.

Dr. Polk presented specimens of the softening of the spinal cord and cancer of the stomach. A history, as follows, accompanied the former specimen:—

A man, aged seventy-six, was admitted to Bellevue Hospital on January 31st, 1876. He had enjoyed excellent health until a year ago, when he began to feel numbness of the lower extremities, and it took six months to develop into paraplegia. Two weeks before his admission into the hospital he fell into a semi-comatose condition, and passed his urine and faeces involuntarily. During this period, however, the paraplegia improved. On admission the sensation in the lower extremities was good, and the paralysis incomplete. He died this day (February 9th).

Autopsy.—On examining the spinal cord, it was found in a condition of yellow softening, extending from the eighth dorsal vertebra to its termination. Calcified plates were also seen, and the gray matter only was involved in the disease. The doctor thought that the disease had first commenced as meningitis. Calcification of almost all the arteries of the body was found, but this was especially marked in the coronary artery. In one of the kidneys a cyst was developed, which was separated from the renal tissue by a calcified plate.

The history accompanying the second specimen was as follows:—

A woman had been admitted to Bellevue Hospital four months ago. Her urine was albuminous at that time, and no other disease but albuminuria was discovered, and she was discharged at the end of two months in an improved condition. Shortly after she again entered the hospital, complaining of the same symptoms; but no albumen was detected in the urine. She improved under the administration of tonics and diuretics. One month ago she suddenly became hemiplegic, and afterward developed bed-sores. The paralysis of the lower extremity improved slightly. She died a few days since.

The autopsy revealed cerebral softening due to thrombosis. The special point of interest was the presence of cancer, involving the lesser curvature of the stomach, and extending to the

duodenum, not producing any constriction of the pylorus, without having given rise to symptoms of that disease (e. g., vomiting, etc.) during life. The kidneys were contracted.

Pericarditis—Myocarditis—Endocarditis.

Dr. Burchard presented a specimen showing peri-, myo-, and endocarditis. A man aged twenty-five, who had been addicted to the use of stimulants for ten or fifteen years, was, on November 29th, 1875, taken with a chill, this being followed by a high temperature, and soon the characteristic pneumonic sputa was seen. On physical examination of the chest, dullness and bronchial respiration were found at the bases of both lungs. On the eleventh day of the disease resolution was progressing, when, in the evening, the patient was seized with a chill, followed by a rise of temperature, and complained of pain in the praecordial region. On examination, fluid effusion was detected in both pleura. Seven days later the diagnosis of pericarditis was made and confirmed by Dr. A. L. Loomis, who saw the patient. Three weeks ago the pleural and pericardial effusion became absorbed. During the patient's illness a syphilitic eruption appeared upon his body. Dr. Loomis saw him again, and diagnosed myocarditis. He died on February 6th.

Autopsy.—The pericardium was the seat of fibrinous exudation. The heart was enlarged, the muscular tissue was found to be supplanted by connective tissue-growth.

Dr. Loomis said that myocarditis was more common in connection with endo- and pericarditis than was generally supposed. He further stated that when he was called to examine this case he had found the heart's action labored, which resembled that caused by dilatation following hypertrophy.

Diphtheria—Pneumonia—Bacteria Discovered in the Blood.

Dr. J. Lewis Smith presented specimens, with a history as follows:—

A boy aged six years was seen on February 2d by Dr. Smith. The patient was vomiting, and his respiration was labored. Temperature 100°, pulse 96. No membrane was visible on the fauces. The urine was normal. The patient could walk about the room. On the 4th the pulse was the same, but the temperature had decreased to 90°. On the morning of the patient's death (Feb. 7th) the temperature ran up to 103°, the pulse being 120. The respiration was extremely labored. The urine contained an excess of urea, and was albuminous two days before death. Quinia, in three-grain doses, had been prescribed.

Autopsy.—The pericardium contained two drachms of transparent serum. The right ventricle of the heart was the seat of a firm white clot, extending to the pulmonary artery. Dark (tarry-colored) clots were also found in the right and left auricles and left ventricle. Dr. Satterthwaite had examined the specimens for Dr. Smith, and had found the diphtheritic exu-

dation to extend from the larynx through the trachea, beyond the bifurcation, and spreading to the bronchi of the third degree (right lung); beyond these points the mucous membrane of the tubes was injected and thickened. The upper lobe, and centre of the upper portion of the lower one, of the right lung, were the seat of croupous pneumonia. The middle lobe was congested. The bronchial glands were enlarged. The tonsils were not much enlarged; their surfaces were the seat of depressions the size of pin-heads. About one-half ounce of blood was taken from one of the ventricles; this was preserved in solution of hydrate of chloral, and at the end of thirty-six hours it was examined microscopically, crenated bacteria, in small numbers, being found. Both kidneys were congested, and the capsules adherent. On their surfaces spots of newly-formed connective tissue were visible. The malpighian bodies were congested, and the convoluted tubes granular. Nothing abnormal was detected about the straight tubes. There was an extravasation of blood throughout. No bacteria were found in the cardiac, pulmonary and renal tissues. Scrapings from the cut surface of the spleen were examined, and multitudes of granules were found; these bodies refracted and resembled oil globules, but no bacteria were recognized. The liver was normal.

Hemorrhagic Pachymeningitis—Syphilitic Pachymeningitis.

Dr. Seguin presented two specimens, viz.: sections of the dura mater, one showing hemorrhagic and the other syphilitic pachymen-

gitis. In connection with the first specimen, the doctor gave the following history: The patient had been exposed to the sun's rays on a hot summer day, and afterward had suffered from headache, just over the coronal suture, in the occipital region, and in the back of the neck. No syphilitic history could be obtained. His pulse was 55. He had symptoms of somnolence and difficulty of deglutition.

Autopsy.—A clot measuring six by four inches was found covering both sides of the hemisphere over the dura mater, and was confined by a delicate membrane. The clot was from one-third to one-half of an inch thick, and was in a semi-fluid state.

The other specimen, showing syphilitic pachymeningitis, consisted of a thickening of the dura mater over the lateral hemisphere, and was obtained from a case presented by Dr. A. H. Smith at a previous meeting of the Society.

Hypertrophy of Cervix Uteri—Amputation by Galvano-Cautery.

Dr. Sell presented a specimen of hypertrophy of the cervix uteri, which he had amputated without hemorrhage by the galvano-cautery. A woman, aged thirty-nine, married for thirteen years and the mother of four children, had been an invalid for four years, suffering from procidentia. She had been treated by her physician for pneumonia, intermittent fever and rheumatism. Dr. Sell had diagnosed hypertrophy of the cervix, which he had amputated as above stated.

EDITORIAL DEPARTMENT.

PERISCOPE.

Section of the Abdomen for Intussusception.

The rather frequent occurrence and very gloomy prognosis of intussusception induce us to give some extracts from recent British papers on its treatment by abdominal section. Three cases were reported before the Medico-Chirurgical Society of London.

The first was related by Mr. Howard Marsh, who performed the operation on an infant of seven months of age. The bowel projected two inches beyond the anus, and at the extremity of the protrusion the ileo-caecal valve was visible, whilst in the abdomen a firm cylindrical tumor was felt extending in the course of the descending colon from the left of the umbilicus to the left iliac fossa. Insufflation and careful distension with lukewarm water having failed to reduce the intussusception, and the child being collapsed and frequently sick, Mr. Marsh

operated. Sickness at once ceased. On the third day the bowels were relieved, and on the fourth the child was convalescent. In this case the intestine had been invaginated for thirteen days, but inflammation only set in twelve or fourteen hours before the operation, and Mr. Marsh expressed the opinion that when other means had failed the operation ought to be undertaken, not only in acute cases of twelve or eighteen hours' duration, but also in chronic ones in which there have been no symptoms of inflammation or strangulation.

The second case was that of an adult woman aged thirty-three. The length of the included bowel was at least eighteen inches. Not one bad symptom occurred, the temperature never rising above normal, and the wound healing by the first intention. In this case hemorrhage, so frequently regarded as a cardinal symptom, did not occur.

The third case was by Mr. Hutchinson, who also made some remarks on the details of the

operation. It occurred in an infant aged six months. The intussusception involved the whole length of the colon, and the ileo-cæcal valve, introverted, constituted its extremity, and was easily felt by the finger in the anus. The symptoms had been the usual ones; they had lasted three days, and the usual method of treatment, perseveringly carried out, had failed. As the child was evidently about to sink, the operation was at once performed. Considerable difficulties were encountered in effecting the reduction of the intussuscepted part. Its neck was tied back in the loin by the meso-colon, and could not be brought into view, and, although there were no adhesions, it was found quite impracticable to draw the intussuscepted bowel out of the sheath. At length it was discovered that although the upper end of the intussusception was fixed, its lower one, containing the sigmoid flexure of the colon, was quite loose. This was readily brought out, and by gently pulling the sheath downward reduction was without difficulty effected. The appearance of the appendix vermiciformis, just at the completion of the reduction, confirmed the opinion formed as to the intversion having begun at the cæcum. Considerable difficulty was encountered in replacing the intestines within the abdomen. They were accordingly punctured with a harelip needle in two or three places, and at the conclusion of the operation the infant was in an alarming collapse. It rallied, however, afterward, took the breast, and passed a motion. Death occurred about six hours after the operation, and the post-mortem showed evidences of recent extensive peritonitis.

In the discussion Dr. West drew attention to the distinction between intussusception in the adult and in the child, pointing out that in the latter the diagnosis is by no means difficult, and that one of the earliest signs is the passage of blood or bloody mucus. Even when the invaginated intestine could not be felt, but there was only indistinct fullness of the abdomen, he thought the diagnosis easy, as also did Dr. E. G. Barnes, in whose practice Mr. Marsh's case had occurred. Both agreed that when other means failed the operation ought to be resorted to. Mr. Thomas Smith argued that the length of the incision was not of much moment, since ovariotomy has taught us that mechanical interference with the peritoneum is not very dangerous. The danger rather lay in the retention of a clot, and all the viscera could be sponged with impunity. He thought it would often be necessary to puncture the intestine. Professor Timothy Holmes thought a long incision facilitated the return of the bowel, and remarked that the operation was usually performed only in hopeless cases. As to the hemorrhage, he observed that the occurrence of blood in a hernial sac shows that it may take place from strangulated intestine. Mr. George Pollock mentioned some experiments which he had made some years ago to determine the danger of over-distension by injection, and which showed that the peritoneum was very apt to crack when

the bowel was only slightly distended; thus peritonitis might be set up. Dr. Hare advocated the injection of ice-cold water to reduce the congestion of the intussuscepted portion, and this could be aided by the application of ice to the abdomen. He thought the cold not only diminished the congestion of the vessels, but also the volume of air in the bowel.

High Temperature.

A case of singularly high temperature is given in the *New York Medical Journal*, from the Mount Sinai Hospital. The history is as follows:—A German woman, aged twenty, was attacked seven months ago with convulsions. She was under treatment by an irregular practitioner before entering the hospital. The treatment consisted in freely bleeding the patient from the arm at short intervals. When she came under observation at the hospital, it was supposed that the convulsions were of a hysterical character, and for this purpose the strong induced current was applied. Some time afterward she noticed a hyperesthesia of the hand, which extended upward, and by degrees involved the arm, shoulder, and side. The temperature was then taken in the rectum, and found to be 110° Fahr. This high temperature lasted only for a very few hours, and then subsided to 99° and 100°. At first it was supposed that the apparent high temperature was due to some imperfection of the thermometer, but with different instruments the same result was obtained. It has been found that the marked increase of temperature occurs with an attack of pain. The diagnosis that has been made is of meningitis affecting the basilar portion of the brain or upper part of the medulla oblongata.

Employment of Medicated Ice.

The following suggestion is made by Mr. Edward Martin, in a letter to the *Lancet*:

"Every practitioner has, at times, to face the difficulties of the scarlatinal throat in young children. It may sadly want topical medication; but how is he to apply it? Young children cannot gargle, and to attempt the brush or spray often fills them with terror. In many cases neither sternness nor coaxing avails. Yet these little ones, in almost every case, will greedily suck bits of ice. This has long been my chief resource where I could not persuade the child to submit to the sulphurous acid spray. Lately, I have been trying an ice formed of a frozen solution of the acid (or some other antiseptic). Though, of course, not so tasteless as pure ice, the flavor is much lessened by the low temperature, and probably also through the parched tongue very little appreciating any flavor whatever, that I find scarcely any complaint on that score from the little sufferers; they generally take to it very readily. The process of making it is very simple. A large test-tube immersed in a mixture of pounded

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ice and salt is the only apparatus required, and in this the solution is easily frozen. When quite solid, a momentary dip of the tube in hot water enables one to turn out the cylinder of ice as the cook turns out her mould of jelly. I have tried the three following formulæ, all of which answer, though I think I prefer the first:—

1. R. Sulphurous acid,	3ss
Water,	3vjss.
Mix and freeze.	
2. R. Chlorate of potassa,	3j
Water,	3j.
Dissolve and freeze.	
3. R. Solution of chlorinated soda,	3ss
Water,	3j.
Mix and freeze.	

"However, the form is of secondary importance, as each practitioner can construct his own. Boracic acid, salicylic acid, or any other harmless antiseptic, with not too much taste, would, doubtless, be as useful as those indicated."

The Elastic Band in Tenotomy.

In the *Canada Medical and Surgical Journal*, Dr. A. A. Henderson, of Ottawa, Ontario, writes:—

A short time ago I was sent for to see Willie T., a healthy, well-developed child, aged twenty months, perfectly formed in every respect, with the exception of deformity of the right foot. I was informed that an operation had been performed upon the foot eleven months previously, and that the usual kind of boot for such cases had been worn by him, but without any beneficial result.

Condition Previous to Operation.—Upon examining the foot, I found the heel well depressed, the tendo-achillis having been divided at the previous operation. The inner margin of the foot, however, was drawn upward, and the anterior portion twisted inward to such an extent that at any attempt to walk the dorsum of the foot pressed upon the ground. I then examined the tendons with a view to operation, and found that the tendon of the tibialis anticus was the cause of the deformity, and that in this case it could be divided most easily just above the ankle-joint.

On December 3d, 1875, assisted by Dr. Sweetland, I operated without chloroform. The foot was firmly held in position by Dr. Sweetland, while I divided the tendon of the anterior tibial muscle, above the ankle-joint, in the usual manner.

The puncture was covered with adhesive plaster, and the foot secured in position by means of a broad strip of plaster placed around it just behind the toes, having a smaller strip inserted so as to form a loop at the outer margin of the foot, just at the root of the small toe. Another broad band of plaster, with a loop formed at its outer portion, was placed around the leg above the knee.

These loops were then connected by an elastic band, composed of two pieces of rubber tubing, attached by means of a hook to the loop at the root of the small toe, and by means of a loop, with tape attached, to the plaster above the knee. The tape was found a great convenience, as a means of regulating the amount of tension required from the rubber.

No boot was worn for fourteen days, and during that time the child was not allowed to walk. The sticking-plaster was renewed from time to time as it became partially detached, and the tension of the rubber was carefully regulated. At the expiration of that time the child was allowed to walk, but, instead of putting on a Scarpa's shoe, I selected a light boot, such as is usually worn by children, and still keeping the band of sticking-plaster around the foot, I passed the loop out through an incision which I made at the outer margin of the boot, and hooked the elastic tubing into it. By this means the foot was prevented from turning in the boot. The other end of the elastic was secured to the back of a belt passed around the waist, and kept in position by passing through a keeper situated at the outer and posterior part of a band passed around the thigh. This enabled the child to walk without the possibility of displacing any of the fastenings, and exercised a proper amount of traction, and in the right direction. The child walked readily with the toes everted, and the sole of the foot placed properly upon the ground.

Radical Cure of Salivary Fistula.

The following case is reported from the clinic of Dr. E. M. Bartlett, in the *St. Louis Clinical Record*. The obstinacy of the lesion renders the account of much value:—

J. H., aged ten years, suffered from an abscess beneath the right ear, at the lower margin of the parotid gland, and applied to a physician for treatment. A free incision was made, pus evacuated, and the patient relieved. The incision did not heal completely, leaving a fistulous opening at the most dependent portion of what had formerly been an abscess, and an almost constant discharge was the result.

This condition continued for seven years. Patient applied to me for treatment one month ago. On examination I found a salivary fistula, opening externally and immediately posterior to the angle of the inferior maxilla. Steno's duct had been divided at a point corresponding with its exit from the parotid gland, and there had been formed an artificial channel leading from the gland downward to the lowest part of the incision, as shown by the cicatrix.

My first effort was to explore the duct of Steno. I passed my probe into the duct to within about three-fourths of an inch of the fistula, where I met an obstruction. Beyond this point the duct had been obliterated. I then cut down, from without, to the point of the probe. I then passed a needle, armed with a strong silk thread, from the opening just

made in the cheek to a point about a line above the fistula, penetrated the artificial channel above the fistula, and, turning the point of the needle downward, brought it out at the fistula, allowing the thread to remain as a seton. In this way I hoped to make an artificial duct from the fistula to the artificial opening just made. After thirty-six hours I removed the seton and passed a small-eye probe along the track of the seton from the artificial opening to the fistula, then armed the probe with a silk thread, having a knot in one end, drew the probe backward and out, leaving one end of the thread on the outside of the cheek at the artificial opening, after having buried the knot at the other end in the artificial channel above the fistula, and then closed the fistula with a suture externally. After the artificial duct from the fistula to the artificial opening in the cheek had been sufficiently established to permit the saliva to flow out freely upon the cheek at the artificial opening, I was ready for the next step in the operation. I then moved the fistula forward on the cheek and closed the fistula behind the angle of the jaw. I wanted to know certainly that an artificial duct had been established from the fistula to the opening made in the cheek before I proceeded further, else I should have brought the thread forward through the natural duct and finished the operation.

I next passed my probe backward through the duct from the inside of the mouth to the artificial opening in the cheek, armed the probe with a silk thread, and again withdrew it, drawing the thread through the natural duct, leaving one end of the thread on the inside of the cheek suspended from the natural opening of Steno's duct, opposite the second upper molar, while a knot in the other end of the thread retained that end in the artificial opening. I then closed the opening in the cheek with plaster, and the saliva has since been flowing out at the natural opening. Both external openings have healed. The saliva readily followed the thread, the thread acting as a conductor, hence I preferred it to silver wire. The cure is radical.

Orchitis Treated by Puncture.

This subject has lately been discussed in the *Lancet*. The well-known surgeon, Mr. T. Holmes, condemns it, and in the debate says:—

"I could produce quite as many witnesses on my side if I chose to argue the question that way; in fact, I have heard the treatment so uniformly reprobated that I innocently believed (so little do we know of each other's practice in this great city) it had been given up, and I was rather doubtful whether it was worth while to notice it. Now I find that in some eleven years (since 1864), Mr. H. Smith has punctured the testicle in more than one thousand cases, though recommending the treatment 'only in the most acute form of the disease.' My ignorance of the benefits of this method is no doubt due, as Mr. Smith says, to my not having met with

cases appropriate for it; but surely that must be his fault, not mine. He must have punctured every testicle in London which required the operation, and in saying this I am sure I am doing less than justice to his surgical activity."

We may add that Mr. M'Gill, Mr. Spencer Watson, and others who have tried the treatment, now restrict it to cases in which there is considerable effusion into the tunica vaginalis, in which it is easy to see that relief to pain, as testified by so many, would follow evacuation of the fluid.

Disinfection for Yellow Fever.

The Scientific American says:—

Whenever a case of yellow fever occurs in New Orleans, the streets surrounding the square are sprinkled with Calvert's No. 5 carbolic acid diluted in 50 parts of water. A large sprinkler on wheels is used for the roadways, and the sidewalks are sprinkled by hand. The grounds of neighboring yards are similarly treated, and the privy vaults disinfected with a solution of zinc-iron chloride. At the termination of the case by death or removal, the infected apartments are fumigated with sulphurous acid or chlorine. The extent of the ground disinfected is according to the lapse of time since the appearance of the fever. The extent of the infection along the ground is about forty or fifty feet daily, so that after some days' delay the whole square must be enclosed with a disinfecting band and the enclosed surface sprinkled.

The Pathology of Hydrophobia.

In one of the late numbers of *Virchow's Archiv*, Dr. Benedikt states that he has examined a number of brains from rabid dogs, and the brain of a man who died from hydrophobia. The results which he obtained, and the conclusions he based upon them, are as follows:—Hydrophobia is a poisoning of the blood, which being latent in the brain for awhile, breaks out at last. This takes place in certain parts of the brain. In dogs, there were found changes in the olfactory gyrus of the anterior lobe, in a fossa which corresponds to the fissure of Sylvius in man, in the lenticular ganglion, and along the trifacial nerve toward its nucleus. The morbid changes seem to begin with a coagulation in the smaller veins, which is followed by increased pressure in the veins. In the course of the now-developing inflammation, the walls of the vessels are penetrated by red and white blood-corpuscles. The inner and middle coats of the vessels are torn in some places, while the outer coat probably becomes softened, and then a number of blood-corpuscles may leave the vessels by the openings thus formed. The blood-corpuscles form along the vessels a number of little abscesses in the brain-substance. The corpuscles begin here to swell, and become at last transparent. The pre-existing cellular elements (of the brain) enclosed by the blood-corpuscles also swell, and become hyaloid. At

last, blood-cells and brain-cells are softened, and changed into a transparent amorphous mass. The miliary abscesses in the brains of men are arranged in clusters around the vessels. There are also masses of yellow pigment along the vessels. These originate from red blood-corpuscles, which run through all stages of swelling. Only the nucleus is pigmented; there are also free nuclei. The appearance of the hallucinations and illusions, as well as of the motor form of psychosis in hydrophobia, is explained by the locality which becomes in this disease affected in the brain. The author does not deny that there may also be similar changes in a number of other organs.

REVIEWS AND BOOK NOTICES.

BOOK NOTICES.

A Manual of General Pathology. For the use of Students and Practitioners of Medicine. By Ernst Wagner, M. D., Professor of General Pathology in the University of Leipzig. Translated from the Sixth German Edition, by John Van Duyn, A. M., M. D., and E. C. Seguin, M. D. New York, Wm. Wood & Co., 1876. Cloth, 8vo, pp. 728.

Mr. Seguin, the editor, in his preface, says of this work; "No book in the English language gives such a thorough *résumé* of the elements of medicine, and in none is the matter so arranged as to be available for both the student and the practitioner." After an examination of several chapters of the work, we desire to testify to the entire correctness of this opinion. Both in the general disposition of the facts collected, and in the exhibition of their bearings on processes of disease, the author has displayed unusual skill.

The leading divisions of the subject are grouped under four general heads, forming so many parts of the volume. These are general Nosology, General Etiology, General Pathological Anatomy and Physiology, and the Pathology of the Blood. Of these, the third is much the most comprehensive, embracing as it does the subjects of inflammation, cancer, fatty degeneration, etc. The most generally interesting, perhaps, is the second part, where are discussed the great questions of the causes of disease. These are divided into internal and external causes, the former including inheritance, age, sex and constitution, the latter all those surroundings which it is the especial province of the sanitarian to look after.

Contagious and epidemic diseases, of course, receive the careful consideration to which they are entitled. As to what is the infecting agent, the author speaks with due reserve; he mentions the various theories proposed, and adds: "Of these, the so-called parasitic theory is at least the most probable. But investigations carried on for the last ten years are, in spite of the declarations of observers, not yet so far removed from doubt that the assumption of a so-called *contagium animatum* can be regarded as assured." This is a laudable distrust, worth recommending to the many writers who now-a-days take the parasitic theory for granted in their articles.

The pages of the work are replete with hints on the practical bearings of pathological facts, and also present numerous references to articles and works on the subjects mentioned.

Lectures on Nursing. By William Robert Smith, Resident Surgeon, Royal Hants County Hospital. Philadelphia, Lindsay & Blakiston, 1876. 1 vol., cloth, 8vo, pp. 228. Price \$2.25.

The author has given to this work the form of lectures, twelve in number, being a revision of those he delivered to the nursing staff of the hospital. The attention which, fortunately, has arisen of late years to the efficient training of nurses will make every work of this kind in demand, and among them the present one will be entitled to a full share of popularity.

Of course, such a subject offers no other opportunity for the display of originality than in lucidity of arrangement and judicious selection. In these respects the author does not seem to us conspicuously happy. Why such incongruous topics as the palatable preparation of medicines, laying out the dead, recipes for poultices and directions for medicated baths should be jumbled together in one lecture, it is hard to guess. Many of the recipes for food are not suited to the American reader; and the same is true of such paragraphs as "the duty of a probationer," etc., which are intended for the English system of nurses and attendants.

The text is illustrated by twenty-seven wood-cuts, and a rather full index is added to the book.

We may say of it, as a whole, that, while it will repay perusal, it leaves plenty of room for a carefully-arranged, thorough American work on the same subject.

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MIND AS A FACTOR OF ORGANISM.

In the general admiration for practical facts and tangible realities, one is apt to forget that what is abstract and ideal is also what alone is true. Knowledge derived from the senses is of itself of no value at all. Physiological studies have abundantly proved that it is fallacious, deceptive, and unreal, giving us images no more like the object itself than a name is like the thing named.

Physiology is now advancing further, and, taking in hand the study of *mind*, is enlarging it rapidly. Dispersing the old entities, faculties and what not, that so long clouded the field, it looks out for functions, the expressions of mind, and when it finds these, it proclaims a corresponding number of mental attributes. Time was when a something called a *psyche* was asserted to be the peculiar property of man.

Des Cartes and his followers defended this notion, and located the seat of this something

in the pineal gland. As distinct from mind, it was subsequently rejected by the German and Scottish philosophers, and is not admitted in the psychology of to-day. No violence is done to man's hope of life after physical death by this acknowledgment, as that which is believed to be his immortal part is recognized by many of the latter schools.

Lately, the mind has received a further extension of its field. The lower animals, even the lowest ones, have been shown by the researches of naturalists to manifest many notions and aims which bespeak for them conscious action with a purpose, very much ahead of what we had attributed to them. The closer study of the history of instinct shows it to be a transmitted memory of ratiocination; unconscious often, but readily traceable to a conscious antecedent act. There are, in fact, very few exhibitions of mind in the highest animals which do not present correlated forms in the lower ones.

But the reader must prepare himself to go a step further than this. Complicated organisms exist below the animal world. The field of vegetable life is there, with its beautiful and varied growths, its strong vitality, its developed reproductiveness. Shall we deny mind to it, off-hand and without inquiry? Or shall we say that, on sufficient evidence, it, too, must be conceded to act in accordance with mental functions?

The latter is the only scientific procedure. To its discussion Dr. W. LAUDER LINDSAY addresses himself in the last number of the *Journal of Mental Science*. From observation, and the comparison of numerous botanical monographs, he shows that common sensation, purposive action, selection or choice, conscious self-direction, preference, spontaneous and deliberate effort, calculation of distance, attachment through preference to place and things, and memory, must be conceded to be shown by plants, and often in a marked degree.

The same conclusions, substantially, are reached by Mr. CHARLES DARWIN in his works

on Insectivorous and Climbing Plants. In the latter he says:

"It has often been vaguely asserted that plants are distinguished from animals by not having the power of movement. It should rather be said that plants acquire and display their power only when it is of some advantage to them; this being of comparatively rare occurrence, as they are affixed to the ground, and food is brought to them by the air and rain."

But the power is in them to move, even when they do not exert it; for the conclusion he reaches is, that this power "is inherited, though undeveloped, in almost every plant;" "that climbing plants have utilized and perfected a widely-distributed and incipient capacity, which, as far as we can see, is of no service to ordinary plants."

The most startling result of these researches, and one which reacts most powerfully to change the theories of mental functions in man and the higher animals, is the legitimate inference they force upon us that will and consciousness—in fact, all mental phenomena—may and do exist in organisms which are destitute of both brain and nervous system, and therefore that mind is something *independent of these*.

This blow staggers the fundamental doctrine of modern "cerebrationists;" it upsets the whole theory so tersely summed up in Mole-schott's phrase, "Without phosphorus there is no thought," by showing that neither phosphorus, brain, nor nerve-cell is needed for thought; it expands our conception of mind, and teaches us that no such shallow theory as attaches it to this or that chemical element, to this or that physiological tissue, is of sufficient depth to meet the requirements of the case; it sets forth mind as a factor of organism, the one inseparable from the other, wherever found.

The United States Medical Directory.

It is proposed to prepare a second revised edition of this work. Physicians who have commenced practice, or changed location during the past three years (other than those whose addresses are on our subscription lists), are requested to forward notice of such changes to this office. Other journals please copy.

NOTES AND COMMENTS.

Formulae from the Pharmacopœia of the Philadelphia Hospital.

Our useful contemporary, the American *Journal of Pharmacy*, has published a number of the formulae for the "house mixtures" in use in the Philadelphia Hospital. As these mixtures are the result of very extended and careful trial, we reproduce several which are of more general interest.

Mistura Anti-rheumatica.

R. Potassii nitratis,	3ij
Vini colchici, radicis,	f.3ij
Spiritus aetheris nitrosi,	f.3ij
Syrupi guaiaci,	f.3ij
Olei gaultheriae,	g. vj.
Aqua,	q. s. ad. f.3vj. M.

Signa.—Dose, a tablespoonful every two hours.

Pilula Anti-neuralgica.

R. Acdi arseniosi,	gr.iv
Strychnis sulphatis,	gr.ij
Extracti belladonnei,	gr.xiv
Cinchonis sulphatis,	3ij
Pilulae ferri carbonatis,	3v. M.

Fiat pilulae cxx.

Signa.—Each pill contains 1-30th grain of arsenic, 1-40th grain of strychnia, 1-5th grain of belladonna, $\frac{1}{2}$ grains of cinchonia, and $\frac{2}{3}$ grains of Vallet's mass.

Mistura Ferri Chloridi Composita (Basham's Mixture).

R. Liquoris ammonii acetatis,	f.3ij
Tincturæ ferri chloridi,	f.3ij
Acdi aceticæ diluti,	f.3ij
Curacao vel alcohol,	f.3ij
Syrupi,	
Aqua,	q. s. ad. f.3vj.

Fiat mistura.

Signa—Dose, a tablespoonful.

Misturi Cosmetica (Goddard's Cosmetic Lotion).

R. Tincturæ benzoini,	f.3ij
Hydrarg. chloridi corrosivi,	gr.vi
Aqua rosea,	f.3vi.

Fiat mistura.

A valuable cosmetic lotion, but must be used with caution, as it irritates some skins.

Syrupus Pectoralis.

R. Ammonii chloridi,	3ss
Syrupi senegi,	f.3j
Misturæ glycyrrhizæ composite,	q. s. ad. f.3vij. M.

Signa.—Dose, a dessertspoonful. Excellent as a general cough syrup.

Tinctura Saponis Viridis cum Pice.

R. Picea liquida,
Saponis viridis,
Spiritus methylici, as 3j M.
Cum leni calore.

Very useful in many skin diseases.

Syrupus Chlorali.

R. Chloralis hydratis, Dlxiv
Tincturae cardamomi, f. 3j
Syrupi, f. 3iv
Aqua cinnamomi, q. s. ad. Oj. M.

Signa.—A teaspoonful contains 10 grains of chloral.

An agreeable vehicle for chloral.

Electricity, Ozone, and Putrefaction.

The *British Medical Journal* remarks that though it is popularly known that after a thunder-storm milk turns, beef-tea and other soups get sour, and meat of all kinds becomes tainted and unfit for food, yet the immediate cause of these phenomena has not, up till now, been satisfactorily explained. M. A. Boillot, who is well known for his researches for the properties of ozone, has lately communicated to the Academy of Sciences certain observations which will throw some light on the subject. During last summer, M. Boillot tried some experiments with a bit of fresh beef, weighing 100 grammes, which he divided into two equal portions. One of these was put into a glass-stoppered bottle containing air, and the other into another glass-stoppered bottle containing ozonated air (five milligrammes to a litre). The size of each bottle was 200 cubic centimetres. Both were placed in a cellar where the temperature was about 59 F. Five days after this, the meat in the first bottle was in a state of putrefaction; the other piece remained unaltered, and was as fresh as on the day it was put into the bottle. On the tenth day it was still unaltered in appearance, and there was no unpleasant smell whatever about it; but the bottle having been opened only for a few seconds, although it was immediately closed, the meat in it was in a state of putrefaction the following day, which M. Boillot attributed to the ingress of air when he opened the bottle. The same experiment was performed with milk; but the air contained in the first bottle was replaced by oxygen. The results were exactly the same; the milk was found to be in a perfect state of preservation in the ozonated air, whereas it had completely turned in the bottle containing oxygen. These experi-

ments offer many suggestions of great interest, and M. Boillot hopes, by further experiments in the same direction, to determine the kind of action which ozone exercises over animal matter, and thus be able to explain the effect produced by thunder-storms on alimentary substances, the importance of which can hardly be overrated.

Notes on the Chemistry of the Urine.

A. Hilger (*Archiv. der Pharm.*, ccvi, 388), after investigating the various tests for albumen in urine, concludes that the following should be employed:—

1. The test with nitric acid.
2. The coagulation test with acetic acid.
3. Bödeker's reaction, precipitating, by potassium, ferro-cyanide after acidification by acetic acid. This test he considers especially valuable.

Dr. C. Neubauer (*Zeitschr. f. Analyt. Chem.*, xv, 115), in commenting on the above, says that Heller's method of coagulating the albumen by nitric acid leaves nothing to be desired in this direction. This consists of adding the previously-filtered urine cautiously to the colorless acid.

Hilger also (l. c., p. 385) describes a urine drawn from a case of phosphorus poisoning, so rich in bile acids that the sodium salts could be separated from 500 c. c. of urine. He used Hoppe-Seyler's method of separation, slightly modified, using Pettenkofer's test for identification.

Kütz (*Centralblatt f. d. Med. Wissenschaften*, 1875, p. 515) reports the results of experiments upon the delicacy of Pettenkofer's test for bile. He finds, first, cane sugar, then fruit sugar (prepared by the action of dilute sulphuric acid upon inulin), and then grape sugar.

E. Vogt (*Archiv. der Pharm.*) examined the urine of a man, who daily, for the past five years, had been taking large quantities of morphia, by the mouth and hypodermically. To his surprise, the results were wholly negative. He then examined the faeces, where it was easily found sufficiently abundant for a quantitative determination. He concludes that in cases of suspected opium-poisoning the faeces should be examined as well as the urine.

A. Rabuteau (*Centralblatt f. d. Med. Wissenschaften*, 1875, p. 462) says that accurate neutralization of the fluid is not necessary in determining chlorine after the method of Mohr. For the determination of chloric acid in the

March 11, 1876.]

Correspondence.

217

urine, which he frequently discovered after the internal administration of chlorates, first acidify with sulphuric acid, and add indigo solution. A fading of the color indicates chloric acid. To determine quantitatively: first determine the amount of chlorine, then change the existing chlorates into chlorides, by ignition, and determine the chlorine again; the difference will give the amount of chlorine in the chlorates.

C. McL., Jr.

The Mancona Bark.

A German pharmaceutical journal says:—

"The West Coast of Africa offers a potent substance, which temporarily awakens interest, not as a medicament, but rather as a poison. This is the so-called *mancona* bark, which is used by several tribes of tropical Africa as an arrow poison, and, like Calabar bean, for the conviction of sorcerers and criminals. It is procured from a tree (known in Africa as *Tali*) of the family *Cæsalpiniæ*, *Erythrophænum Guineense*, G. Don. The bark is hard, fibrous, without odor, and when powdered excites violent sneezing. According to Gallois and Hardy, who have experimented on animals with an extract prepared from the bark, its final effects are those of a muscular and heart poison, so that it is associated in properties with *digitalis* and *hellebore*, a fact which is scarcely favorable to its employment in medicine."

Tumors in the Brain.

The peculiar difficulties in diagnosing these lesions give interest to a case reported to an English district medical society by Dr. Bramwell.

The tumor was of the size of a greengage plum, quite round, smooth on the surface, of a pale yellow color. It sprang from the dura mater, just under the tentorium cerebelli, on the left side. It had caused a deep depression in the left lobe of the cerebellum. There were no signs of inflammation around the tumor; no congestion, no softening. The patient, a woman aged 64, was admitted under Dr. Bramwell's care three weeks before her death. She had tumbled down stairs. On admission, she was semi-comatose. She continued to be stupid and unable to give any account of herself or of her complaints. She frequently vomited. Every now and then, she put her hand to her head, as if in pain. There was no definite paralysis. She could move both arms and legs, but could not

stand. The motions were passed involuntarily. There was no deviation of the eyes. She apparently saw well. The pupils were equal, and moderately contracted. On ophthalmoscopic examination, the right disc was found to be a little redder than the left. The veins in the right eye were somewhat enlarged. There was no swelling of the disc. She died in a convulsion, the right side being most affected. The tumor above described was found. There was also a small clot, partly discolored, just outside the right corpus striatum.

A Circular to Some Subscribers.

A certain number of subscribers have been sent, this week, a printed circular, calling attention to the fact that bills for the current year were enclosed in the numbers for January 29th and February 5th, to all who had not then paid up. We earnestly request that all who owe, and have not noticed those bills, will write us or remit; and that those who receive the circular alluded to will read it carefully, and respond. Few know the heavy expense attending periodical publications, and the necessity for prompt payment on the part of subscribers, in order to maintain the highest journalistic efficiency.

CORRESPONDENCE.

A Case of Ante-Partum Hemorrhage.

ED. MED. AND SURG. REPORTER:—

The following report of a case of ante-partum hemorrhage, terminating in the death of both mother and child, may be of sufficient interest to the profession to justify its publication in your valuable journal.

On the morning of December 27, 1875, I was called up about three o'clock, by J. K., who informed me that his wife had been taken in labor that night, and he had called on Dr. George W. Pettit, of Petersburg, Ohio, his family physician, to attend on her; that when they had arrived at his house, they found her very faint, from loss of blood, and that Dr. Pettit had asked him to go for me in consultation. I immediately repaired to the scene of the difficulty, and found upon my arrival that the case had, through the judicious management of Dr. Pettit and the assistance of nature, assumed a more favorable aspect. Dr. Pettit had given her three five-grain doses of quinæ sulph., and used other means usually resorted to in such cases to check the hemorrhage and establish a reaction. I learned from him that he had attended her in her six previous confinements, and that she had always got along

very well; that he had found her much exhausted from ante-partum hemorrhage, and that he had removed nearly the full of a night vessel of coagulated blood; that upon her attempting to raise her head she had fainted away, and that he had made a vaginal examination and found the parts in a normal condition, as follows: the os uteri was not dilated, but was sufficiently dilatable to enable him to make out a head presentation. The woman had rallied, was resting very comfortably, and had had but a few slight pains since Dr. Pettit's arrival. He assured me that the placenta was not within reach of the finger, and that we had not a case of placenta previa to deal with.

I suggested that probably the case was one in which the placenta had in some way become detached from the uterus, and thus caused the hemorrhage. The previous history tended to confirm this opinion, as the woman had lifted rather heavily about three weeks before, and from that time dated her illness. Dr. Pettit had prescribed for her, about a week after this occurrence, and relieved her of a slight wasting. The Doctor had not heard of her since, till he had been called to wait on her in her confinement. I made an examination, and found the case as the Doctor had reported it to me. The hemorrhage had ceased before I came, and the woman continued to improve in strength and spirits. So there being no signs of labor coming on soon, I proposed to Dr. Pettit that he visit those of his patients who demanded attention, and I would remain till he came back, and then I would go home, leaving the patient in his care.

This suggestion meeting with Dr. Pettit's approval, he left me in charge of the case, promising to return as soon as possible. Shortly after Dr. Pettit had gone, the labor began to progress rapidly, without hemorrhage or a single unfavorable symptom. When the os uteri was sufficiently dilated to allow the head to pass, I ruptured the membranes.

The labor still continued to progress favorably, and we all felt like congratulating ourselves upon the prospects of a speedy termination of the labor, and with it the termination of our fears and anxieties for our patient's safety. She was hopeful, and expressed herself as feeling strong and equal to the emergency. Matters were progressing in this manner when, like a clap of thunder in a clear sky, the patient uttered an exclamation, and went into a convulsion; with the aid of my assistants, I placed her in position, and delivered her with forceps. I think the time occupied in delivering her did not exceed five minutes. The child, a girl, was dead, and looked as though the body had been emptied of all its blood. The placenta was at the os uteri, detached, and was easily removed by traction on the cord. There was no hemorrhage during the delivery of the child or the placenta, nor for some time afterward.

In the meantime, the woman had gradually returned to consciousness, and the convulsions did not again recur, but the pulse, which before

had nearly regained its natural strength and frequency, at once, upon the occurrence of the convulsion, became small, frequent, and very feeble, indicating a prostration of the vital powers bordering on syncope; from this condition she never rallied. I remained anxiously at her bedside, noticing her pulse, but could not detect any change in its character. I noticed she was wasting a little, and upon attempting to check it by pressing upon the uterus and thus securing its contraction, I found that it was pretty well contracted, and that the hemorrhage was rather passive than active in character. I elevated the foot of the bed, in order to throw as much blood to the brain as possible, and dispatched a messenger for Dr. Pettit. In a short time he arrived, and by our united efforts and the assistance of nature we succeeded in checking the hemorrhage. Still the patient did not rally. Dr. Pettit and I remained watching her till about four o'clock P. M., when he received an urgent call to visit a patient a short distance away, and I again consented to remain till his return. Some time after he had gone I noticed that the patient began to grow restless and wanted to change her position in bed frequently.

I made an examination, and could not find that there was any hemorrhage, open or concealed. This condition of affairs continued till about six o'clock P. M., when she began to complain of a severe pain in the region of the umbilicus, and died in less than twenty minutes. I asked to be allowed to make a post-mortem examination, but my request was refused. The above report of the case is submitted without remarks, believing the intelligent physician will thus be the better enabled to draw his own practical conclusion therefrom. H. NYE, M. D.

Enon Valley, Pa., March 3d, 1876.

Bowel Affections—Toothache.

ED. MED. AND SURG. REPORTER:—

In the number of your journal for September 7th, 1872, Dr. Downing called attention to the following "New combination for bowel affections," asking other physicians to try it and report the result.

The formula is as follows:—

R.	Socotrine aloes, powd.,				
	Sulph. potash, powd.,				
	Bicarb. soda, aa.	3j			
	Cloves, powd.,		3ss.		M.

Divide into twelve powders.

To one of these powders he added three tablespoonfuls of boiling water, giving the whole at one dose—as hot as could be borne—to an adult. To be repeated every hour. To children one teaspoonful, to be given every half hour.

The remedy was warmly recommended in all cases of cholera morbus, diarrhoea, and dysentery.

Since I first noticed the above-mentioned combination, now four years, I have been using

it, with uniform satisfaction, in the above-named troubles as seen in children, especially in what we usually term "summer complaints," and "teething diarrhoea." My plan of administering is somewhat different from Dr. Downing's; for instance, I add one teaspoonful of the powder to a teacup of boiling water; when cool, give a teaspoonful every hour till the discharges become normal in frequency and color. The approaching period when these troubles set in, and the confidence I have in the remedy, induced me to pen this, recommending it as a safe and efficient remedy.

Toothache.—You will do something for the afflicted, and possibly preserve the morals of many, by saying to your readers that acetate of lead, applied on moistened cotton, will relieve most cases of this, Burns' "hell of diseases." As fast as it dissolves, spit out, and re-apply. I think it fails less than any other remedy I have prescribed.

M. J. ELEY, M. D.

Lafayette, Ala.

Treatment of Tapeworm.

ED. MED. AND SURG. REPORTER:—

Having had but two cases of tapeworm, and having had success with both of them, I would, if acceptable, like to lay my treatment before your many readers.

After ordering a dose of castor-oil, I have the patient to abstain from food for one day; then administer the following—

R. Pepo, 3vj
Oleo resina filicis, fl. 3ss
Aqua destill., q. s. ad. 3x.
Fiat emulsio.

Sig.—Take half in the morning, the other half in the evening, followed by a large dose of castor-oil.

The pumpkin-seed should be pulverized, hull and all.

If any of your readers find it a success, they will greatly oblige by informing me of the same.

J. A. AVERDICK, M. D.

Covington, Ky., Feb. 21, 1876.

Four at a Birth.

ED. MED. AND SURG. REPORTER:—

In March, 1855, Mrs. Cole, mother of four children and wife of a brick-mason living in this vicinity, was delivered of four children at one birth. They were about two months premature, all girls, and all alive. One died soon after birth, the others lived till next day, and one or two lived two days. All were well developed; the largest weighed four pounds; average weight, three and three-quarter pounds. There were two placentas. The premature delivery was supposed to have been induced by over-exertion and excitement in assisting to extinguish a "fire in the woods" which was about to consume the farm at which they were living. The woman is yet living, but has had

no more children. She became blind soon after her confinement, from amaurosis.

J. M. TAYLOR, M. D.

Corinth, Miss.

NEWS AND MISCELLANY.

American Medical Association.

The Twenty-seventh Annual Session will be held in the city of Philadelphia, Pa., on Tuesday, June 6, 1876, at 11 a. m.

"The delegates shall receive their appointment from permanently-organized State Medical Societies, and such County and District Medical Societies as are recognized by *representation in their respective State Societies*, and from the Medical Department of the Army and Navy of the United States."

"Each State, County, and District Medical Society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number; *Provided*, however, that the number of delegates for any particular State, Territory, county, city, or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

Secretaries of Medical Societies, as above designated, are earnestly requested to forward, at once, lists of their delegates, in order that the Committee of Arrangements may be enabled to form some idea of the number likely to be present.

"The Chairmen of the several sections shall prepare and read in the general sessions of the Association papers on the advances and discoveries of the past year in the branches of science included in their respective sections, * * * *."

—*By-Laws, Art. II, Sect. 4.*

Practice of Medicine, Materia Medica and Physiology:—Dr. Francis G. Smith, Philadelphia, Pa., Chairman; Dr. B. A. Vaughan, Columbus, Miss., Secretary. Committee appointed to report to this section, *On Clinical Observations*:—Dr. N. S. Davis, Ill., Chairman; Dr. H. A. Johnson, Ill.; Dr. J. B. Johnson, Missouri.

Obstetrics and Diseases of Women and Children:—Dr. S. C. Busey, Washington, D. C., Chairman; Dr. Robert Battey, Atlanta, Ga., Secretary. Committee appointed to report to this section, *On the Connection of the Hepatic Circulation with Uterine Hyperæmias, Fluxions, and Inflammations*:—Dr. L. F. Warner, Mass.

Surgery and Anatomy:—Dr. Alonzo Garcelon, Lewiston, Me., Chairman; Dr. E. T. Easley, Dallas, Texas, Secretary.

Medical Jurisprudence, Chemistry, and Psychology:—Dr. E. Lloyd Howard, Baltimore, Md., Chairman; Dr. V. L. Hurlbut, Chicago, Ill., Secretary.

State Medicine and Public Hygiene:—Dr. R. C. Kedzie, Lansing, Mich., Chairman; Dr. Ezra

M. Hunt, Metuchen, N. J., Secretary. Committee to report to this section on Form of Bill to Establish a National Department of Public Health at Washington—Dr. H. B. Baker, Mich., Chairman; Dr. H. A. Johnson, Ill.; Dr. J. M. Toner, D. C.

“Papers appropriate to the several sections, in order to secure consideration and action, must be sent to the Secretary of the appropriate section at least one month before the meeting which is to act upon them. It shall be the duty of the Secretary to whom such papers are sent to examine them with care, and, with the advice of the Chairman of his section, to determine the time and order of their presentation, and give due notice of the same. * * * * *—By-Laws, Art. II, Sect. 5.

The following Committees are expected to report:—

On Mechanism of Accommodation of the Eye, Dr. D. S. Reynolds, Ky., Chairman.

On New Remedies, Dr. Austin Flint, Jr., N. Y., Chairman.

On Medical and Surgical Uses of the Aspirator, Dr. E. S. Gaillard, Ky., Chairman.

On Influence of Climate on Pulmonary Diseases in Minnesota, Dr. Franklin Staples, Minn., Chairman.

On the same in Colorado, Dr. Chas. Denison, Col., Chairman.

On the same in Florida, Dr. E. T. Sabal, Fla., Chairman.

On Proper Legislation to Prevent the Spread of Syphilis, Dr. Samuel D. Gross, Pa., Chairman.

On Prize Essays, Dr. Samuel D. Gross, Pa., Chairman.

On Necrology, Dr. S. C. Chew, Md., Chairman.

On Rank of Medical Corps of the Army, Dr. H. A. Johnson, Ill., Chairman.

W. B. ATKINSON, M. D.,
Permanent Secretary, No. 1400 Pine street,
S. W. corner of Broad street, Philadelphia.

Medical Alumni Association of the University of Michigan.

An association of the graduates of the medical department of the University of Michigan has been formed, with the following officers:—President, R. C. Kedzie, Lansing, class of 1851. First Vice-President, B. Barnum, Jackson class of 1854. Second Vice-President, J. J. Mulheron, Detroit, class of 1869. Third Vice-President, I. E. Brown, Monroe, class of 1873. Fourth Vice-President, C. N. Metcalf, Eaton Rapids, class of 1872. Fifth Vice-President, W. J. Herdman, Zanesville, O., class of 1875. Secretary, W. F. Breakey, Ann Arbor, class of 1859. Treasurer, John Kapp, Ann Arbor, class of 1868. It is urgently requested that all alumni who learn of the organization will promptly forward to the Secretary their own address, and that of any alumni they may know; also the names of any they may know who have died, with any interesting facts of their professional lives, and of the time and place and

circumstances of their death. And that all who cannot meet will send some greeting to those who attend.

—The Philadelphia Dental College graduated a class forty-two in number last week.

QUERIES AND REPLIES.

Letter.

J. W. P., of Pa.—For an obstinate case of tetter, when carbolic acid fails, cut the beard short, pluck out every diseased hair, and apply an ointment like the following:—

R. Sulph. lot.,
Hydrarg. precip. alb., aa one scruple
Acid carbolic, ten drops
Adipis, one ounce, M.

Repeat this as long as the hairs show disease.

Practicing in Great Britain.

EDITOR REPORTER.—Please inform a reader of your valuable REPORTER if a practitioner of medicine, being a graduate of one of our colleges, is entitled to practice (for pay) in Great Britain; as I have been informed that a law has been recently enacted prohibiting all practitioners, excepting graduates of British colleges, from practicing in England.

ALPHA.

Reply.—A license must be obtained from an authorized body, but the diploma of a foreign school in good standing will be recognized.

OBITUARY.

MRS. LOUISA A. GROSS.

In our last number we had the painful duty of announcing the death of Mrs. Louisa A. Gross, the wife of Professor S. D. Gross. From an appreciative notice in one of our dailies we take the following extract:—

“Mrs. Gross was no ordinary woman. Gifted by nature with a vigorous intellect, she had, by extensive reading and close observation, so cultivated it that there were few subjects upon which she could not converse, so as not only to give pleasure, but also to instruct.

“Her memory was remarkable, and enabled her, at will, to refer to almost any fact that she required to illustrate or adorn the subject of her conversation. Is it any wonder, then, that she was the idol of the social circle?

“It is, however, at her own home, surrounded by those she loved and who loved her so well, that we delight most to remember her. It was there, indeed, that Mrs. Gross reigned supreme, possessing, as she did, all the domestic and household virtues in a degree that is rarely met with in any one; not, certainly, in one whose cultivation and attractions made her the necessary recipient of so much of the homage of general society.”

DEATHS.

KELEMEN.—At the country residence of Attila J. Kelemen, M. D., Chester, Connecticut, at a quarter past two A. M. on Thursday, August 12th, suddenly and unexpectedly, of heart disease, his only daughter, Allie Louise Kelemen, aged 24 years.